

## Reading into the future and preparing for it

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At the time of writing much of the world is in political and economic turmoil. It was difficult to have foreseen the severe consequences of this and to have been prepared with effective ameliorative remedies. So often the consequence of gradually developing situations is an accelerative impact which comes as an unpleasant surprise. We are caught unprepared.

Medicine and doctors globally are undergoing such a shift. This may not seem to affect the everyday lives of clinicians and patients at a local level but the impacts are certainly having painful effects in most western countries. Healthcare delivery is in trouble and the easiest of immediate solutions, that of throwing more money at the system, is not going to work on an immediate basis. In any case, the prevalent problem in most countries (ironically in the more affluent western countries) has been the progressive limitation of resource for healthcare against a rising cost and demand burden. Unfortunately, there is no guarantee that things will get better.

The Changing Face of Medicine (CFM) is an initiative originating in the UK. It is akin to a think tank and it aims to review our current situation, particularly around the role of doctors, with a view to projecting into the future. It is a brave initiative which recognises that things may not necessarily get better, say, over the next 20 years. Indeed, many of the tenets of good care we hold dear in medicine, such as human factors and access and continuity of care are eroding at an alarming pace and with little sight of effective solutions.

The way we have practised medicine in the past may become very difficult. Some of the causes are obvious – in many countries there is a shortage of

doctors within their care models, not least in the UK with its National Health Service. The high cost of secondary and tertiary care has put an unbearable burden on primary care services. These struggle to provide access for patients and carry an increasing load of generalist functions as well as specialist spill over tasks that secondary care teams cannot provide. Silo care, with often visibly physical and economic barriers between specialisms mean that the patient is akin to a subject in a pinball machine, bounced from one speciality to another with little overarching care. The older patient with multiple problems is most at risk and there seem to be few signs of this letting up.

Associated with dissatisfaction amongst patients is the high toll on doctors themselves. Clinician wellbeing is a hot topic in most countries with data clearly showing high rates of stress, burnout and depression. Large numbers of doctors are leaving the profession early and younger ones are choosing career pathways that avoid the stressful grind of commodified, resource driven and corporatized health services.

Against this backdrop there are legitimate questions to be asked. Does the increasing trend towards clinical specialisation really require the conventional route to medical training and graduation? For example, in the UK a large proportion of gastro-intestinal endoscopies are performed by specially trained nurses. Does an interventional doctor specialising in a specific procedure need to undergo the conventional, long undergraduate training of doctors as at present? Physician Assistants, of whom there are over 2000 now in the UK, and who are GMC registered, are increasingly taking on the burden of patient care. They undergo a two-year training

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programme and in many circumstances are indistinguishable from their medical counterparts. Why do all doctors need a five-year medical school degree followed by innumerable junior jobs? Medical educators and regulators in all countries, not least in the low-income countries, need to look again at evolved and fit for specific purpose curricula. Generalists, for example, may need a longer training pathway different from that for single task specialists. There may not be much to be gained from sticking with age old traditions in a new, technological, digitised and specialised medical world.

A factor that the profession has had problems getting to grips with is the changing relationship with the patient. Whilst an apostolic or paternal approach may be considered appropriate in less sophisticated settings the public is fast learning to use digital materials. The internet is open to all and medical knowledge is no longer the sacred domain of the learned doctor. Knowledge is democratised and this needs a new compact between the public and the clinician: the situation is already being driven by societal shifts. Delayed and missed diagnoses and mismanagement is less easily forgiven or forgotten – whilst the doctors may have great overall knowledge and wisdom the patient is the real expert in their own problem. As a patient at one of our CFM webinars said, *“As a patient I bring expertise about my own conditions. However, I do not have the expertise that the medical profession has about 101 other illnesses, so that is their speciality and their responsibility. My responsibility and knowledge is about my conditions. I think this is often ignored: the medical profession does not respect patients for what they know”*. This requires, and even more so in the future, an interactive dialogue with the patient. We need a renewal of our

role, awareness of our limitations with a renewed vocation to serve.

The future is also exciting. Technology, Informatics and Artificial Intelligence (AI) offer opportunities unforeseen even a few years ago. The da Vinci robotics surgical system offers the tantalising possibility of operating with great precision on a patient from thousands of miles away. AI-based reading of scans and histology slides offer possibilities of accurate diagnoses and genotyping of lesions without sequencing. Like mobile phones many technologies will supplant conventional systems: AI is likely, through machine learning, to offer more accurate diagnosis at an earlier stage, at least with the accompaniment of a human decision maker. Machine-learned devices may perform many routine as well as complex surgical procedures, with the clinician only on stand-by. Add to this the opportunity of gene based early diagnoses, such as for disorders detected during infancy as well as personalised medicine, and we have a major transformation in the way medical care is delivered. Already, tumour therapies are geared to a lesion’s genomic make up: an extension of these technologies into pharmacogenomics opens the very welcome ability to tailor therapies for everyday conditions, such as hypertension, to the individual patient.

The future is therefore exciting and this is a good time to be training in medicine if we keep an eye to the future. We need to be prepared to face up to current professional and system limitations and to start to pry into and to prepare for this future. As medicine is a global phenomenon no particular country will be able to stay outside the new orbits. And who knows, there may be no need for the doctor as we know it now, within 20 years!